Case 108: Acute on Chronic Pain

Station #: N/A

Patient Information

Name: Jean Clark
Age: as SP appears (range 30-60)
Marital Status: married, heterosexual
Children: yes
Occupation: Home Health Aide
Pain complaint: Acute on Chronic pancreatitis
Setting: You are the resident caring for the patient admitted last night for acute on chronic pain from idiopathic pancreatitis, which has been managed for 4 years with long- and short-acting opioids by the PCP and input from the outpatient GI clinic. The patient had a celiac plexus block, which was ineffective and caused hypotension and diarrhea. The patient takes amitriptyline 50 mg po qd and duloxetine 60 mg po qd for pain and depression, as well as pancreatic enzymes. There is a controlled substances agreement with the PCP and there have been no red flags.

The patient took extra short-acting opioids for increasing pain. The patient presented to the ED with epigastric pain, nausea and said, "I ran out of pain medications." Abdominal CT showed pancreatic calcifications but no ductal dilatation, mass, fluid collection or stone; no ascites. KUB and upright films without air-fluid levels. Complete metabolic panel within normal limits, and stool guiac negative. Urine and serum toxicology was positive for opioids and benzodiazepines, and negative for other substances (including alcohol). Based on the patient's severe pain, mildly elevated lipase level, nausea and dehydration, the patient was admitted to the hospital medicine team for bowel rest, IVF and pain control. Patient is NPO and receiving morphine 1 mg IV q 4 hrs PRN with minimal effect.

Prescription drug monitoring program review shows oxycodone prescriptions only from the PCP's office, a monthly prescription for clonazepam from the same mental health provider (consistent med, dose refills and prescribers).

Learner tasks:
1. Develop a treatment plan for patient's acute pain episode using opioids and non-pharmacologic treatment in a way that adjusts for baseline level of opioid tolerance.
2. Discuss the risks of taking opioids in amounts greater than instructed and in combination with other sedating pharmaceuticals (benzodiazepines).
3. Build a partnership with the patient to set the stage for an enhanced monitoring plan after discharge as part of the current controlled-substances agreement with the PCP.
4. Counsel the patient on the signs and symptoms of withdrawal and overdose, and introduce the concept of a nasal naloxone overdose reversal kit for family members.

Use this space to record feedback for the learner that supports his/her ongoing review and learning:

Notes/Observations:

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